

10568

CERTIFICATE OF DEATH

Reg. Dist. No.

106

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Charles</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pisgah</i>				c. LENGTH OF STAY IN 1b <i>6 wks</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Katherine</i> Middle <i>Jean</i> Last <i>Butler</i>				4. DATE OF DEATH Month <i>October</i> Day <i>28</i> Year <i>1957</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>Negro</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Sept. 10, 1957</i>	
9. AGE (In years lost birthday) yfs. <i>1</i>		IF UNDER 1 YEAR Months <i>1</i> Days <i>18</i>		IF UNDER 24 HRS. Hours <i></i> Min. <i></i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None (Infant)</i>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>							
13. FATHER'S NAME <i>Odell D. Butler</i>				14. MOTHER'S MAIDEN NAME <i>Elizabeth M. Bowman</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT Address <i>Odell D. Butler, Pisgah, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchopneumonia, Septic</i> <i>480X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>480X</i> DUE TO (c) <i>480X</i> INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>None</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>Oct 24</i> , 1957, to <i>Oct 28</i> , 1957, that I last saw the deceased alive on <i>Oct 24</i> , 1957, and that death occurred at <i>4:30 A.M.</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Frank A. Susan</i> M.D.				ADDRESS (Street, city or town, state) <i>Indian Head, Del.</i> DATE SIGNED			
PHYSICIAN'S NAME (Type) <i>Frank A. Susan M.D.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>10-28-57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Smith Chapel</i>		22d. LOCATION (City, town, or county) (State) <i>Pisgah Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>None (Father will bury child)</i>				24a. REC'D BY REGISTRAR DATE <i>NOV 12 1957</i>		24b. REGISTRAR'S SIGNATURE <i>Mrs. Odey Loney</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

See Code 111

1. NAME OF DECEASED		2. SEX		3. AGE	
4. RACE		5. OCCUPATION		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF CORONER		15. SIGNATURE OF WITNESSES	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF NEXT OF KIN		18. SIGNATURE OF CLERGYMAN	
19. SIGNATURE OF CHURCH		20. SIGNATURE OF FUNERAL HOME		21. SIGNATURE OF BURIAL PLACE	
22. SIGNATURE OF INTERMENT		23. SIGNATURE OF CREMATION		24. SIGNATURE OF OTHER	
25. SIGNATURE OF OTHER		26. SIGNATURE OF OTHER		27. SIGNATURE OF OTHER	
28. SIGNATURE OF OTHER		29. SIGNATURE OF OTHER		30. SIGNATURE OF OTHER	
31. SIGNATURE OF OTHER		32. SIGNATURE OF OTHER		33. SIGNATURE OF OTHER	
34. SIGNATURE OF OTHER		35. SIGNATURE OF OTHER		36. SIGNATURE OF OTHER	
37. SIGNATURE OF OTHER		38. SIGNATURE OF OTHER		39. SIGNATURE OF OTHER	
40. SIGNATURE OF OTHER		41. SIGNATURE OF OTHER		42. SIGNATURE OF OTHER	
43. SIGNATURE OF OTHER		44. SIGNATURE OF OTHER		45. SIGNATURE OF OTHER	
46. SIGNATURE OF OTHER		47. SIGNATURE OF OTHER		48. SIGNATURE OF OTHER	
49. SIGNATURE OF OTHER		50. SIGNATURE OF OTHER		51. SIGNATURE OF OTHER	
52. SIGNATURE OF OTHER		53. SIGNATURE OF OTHER		54. SIGNATURE OF OTHER	
55. SIGNATURE OF OTHER		56. SIGNATURE OF OTHER		57. SIGNATURE OF OTHER	
58. SIGNATURE OF OTHER		59. SIGNATURE OF OTHER		60. SIGNATURE OF OTHER	
61. SIGNATURE OF OTHER		62. SIGNATURE OF OTHER		63. SIGNATURE OF OTHER	
64. SIGNATURE OF OTHER		65. SIGNATURE OF OTHER		66. SIGNATURE OF OTHER	
67. SIGNATURE OF OTHER		68. SIGNATURE OF OTHER		69. SIGNATURE OF OTHER	
70. SIGNATURE OF OTHER		71. SIGNATURE OF OTHER		72. SIGNATURE OF OTHER	
73. SIGNATURE OF OTHER		74. SIGNATURE OF OTHER		75. SIGNATURE OF OTHER	
76. SIGNATURE OF OTHER		77. SIGNATURE OF OTHER		78. SIGNATURE OF OTHER	
79. SIGNATURE OF OTHER		80. SIGNATURE OF OTHER		81. SIGNATURE OF OTHER	
82. SIGNATURE OF OTHER		83. SIGNATURE OF OTHER		84. SIGNATURE OF OTHER	
85. SIGNATURE OF OTHER		86. SIGNATURE OF OTHER		87. SIGNATURE OF OTHER	
88. SIGNATURE OF OTHER		89. SIGNATURE OF OTHER		90. SIGNATURE OF OTHER	
91. SIGNATURE OF OTHER		92. SIGNATURE OF OTHER		93. SIGNATURE OF OTHER	
94. SIGNATURE OF OTHER		95. SIGNATURE OF OTHER		96. SIGNATURE OF OTHER	
97. SIGNATURE OF OTHER		98. SIGNATURE OF OTHER		99. SIGNATURE OF OTHER	
100. SIGNATURE OF OTHER		101. SIGNATURE OF OTHER		102. SIGNATURE OF OTHER	

RECEIVED
NOV 12 1957
BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be for the medical examiner. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10569

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) a. STATE b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Newport</i>		c. LENGTH OF STAY IN 1b <i>x2 Newport Md.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>BABY Boy</i>		4. DATE OF DEATH Month <i>10</i> Day <i>8</i> Year <i>1957</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-8-57</i>
9. AGE (In years last birthday) <i>10</i>		IF UNDER 1 YEAR Months <i>1</i> Days <i>1</i> Hours <i>1</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Md</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>James Elmer Dorsey</i>		14. MOTHER'S MAIDEN NAME <i>Genevieve Cecilia Arnold</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 762.5 IMMEDIATE CAUSE (a) <i>Spontaneous 27 wks - wt 4#</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>At birth</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>E. J. E. E. L. E. N</i>		DATE SIGNED <i>10-9-57</i>	
EXAMINER'S NAME (Type) <i>E. J. E. E. L. E. N</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8-19-1957</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St Marys</i>		22d. LOCATION (City, town, or county) (State) <i>Newport Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Archibald Mc Sappatawood</i>		24a. REC'D BY REGISTRAR DATE <i>10/14/57</i>	
24b. REGISTRAR'S SIGNATURE <i>William H. Porey</i>			

4000299XV2

RECEIVED

707 16 1957

RECEIVED

10570

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Physicians Memorial Hospital</u>				e. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Tyrone</u> Middle <u>Sylvester</u> Last <u>Dyson</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>9</u> Year <u>1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-7-57</u>	9. AGE (In years lost birthday) yrs. <u>1</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	IF UNDER 24 HRS. Min. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Joseph Earle Lee</u>				14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Dyson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mother</u>		Address <u>Spring Hill, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.5</u> DUE TO <u>Allecton's</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Granuloma 23 yrs</u> DUE TO (c) <u>2nd 2# 8/3</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10-9-57</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>10-7-1957</u> , to <u>10-9-1957</u> , that I last saw the deceased alive on <u>10-9-1957</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>La Plata, Md.</u> DATE SIGNED <u>10-9-57</u>							
ACTUAL SIGNATURE <u>E. J. Edelen</u> M.D.				PHYSICIAN'S NAME (Type) <u>E. J. EDELEN M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-11-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Severed Heart</u>		22d. LOCATION (City, town, or county) <u>La Plata, Md.</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Archie Mc</u>				24a. REC'D BY REGISTRAR DATE <u>10/14/57</u>		24b. REGISTRAR'S SIGNATURE <u>Julia H. Pusey</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2066192XV1

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint handwritten name]		SEX [Faint handwritten sex]		AGE [Faint handwritten age]	
DATE OF DEATH [Faint handwritten date]		PLACE OF DEATH [Faint handwritten place]		TIME OF DEATH [Faint handwritten time]	
CAUSE OF DEATH [Faint handwritten cause]		MANNER OF DEATH [Faint handwritten manner]		PLACE OF BURIAL [Faint handwritten place]	
SIGNATURE OF PHYSICIAN [Faint handwritten signature]		SIGNATURE OF REGISTRAR [Faint handwritten signature]		SIGNATURE OF WITNESS [Faint handwritten signature]	
CITY [Faint handwritten city]		COUNTY [Faint handwritten county]		STATE [Faint handwritten state]	

RECEIVED
 OCT 16 1957
 BUREAU V. 2

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2

OCT 16 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The original copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10572

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CHARLES</u>		STATE <u>Md.</u>		COUNTY <u>Chas</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>LAPLATA</u>		LENGTH OF STAY (in this place) <u>1 day</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bryans Road</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Physician Menard</u>		STREET ADDRESS <u>1</u>					
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>CHARLES EMMETT GARLAND</u>				4. DATE (Month) (Day) (Year) OF DEATH <u>Oct 13</u> 19 <u>57</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>	8. DATE OF BIRTH <u>27 Jan 1882</u>	9. AGE last birthday <u>75</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Builder</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia, Charlottesville</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>George (?) GARLAND</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-03-7416</u>		17. INFORMANT & ADDRESS <u>Mrs. Mable Garland Bryans Road</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
454x IMMEDIATE CAUSE (A) <u>Respiratory Collapse</u>						<u>12 hrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Emboli</u>						<u>2 min</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Aortic-iliac thrombosis</u>						<u>3 days</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>CVA emboli left side</u>						<u>3 years</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M. M. Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12 Oct</u> , 19 <u>57</u> , to <u>13 Oct</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>13 Oct</u> , 19 <u>57</u> , and that death occurred at <u>13 Oct</u> , 19 <u>57</u> , from the causes and on the date stated above.							
SIGNATURE <u>Dr. Wooddy MD</u>				ADDRESS (Street, city, town, state) <u>La Plata, Md.</u>		DATE SIGNED <u>13 Oct 57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10-15-57</u>		NAME OF CEMETERY OR CREMATORY <u>Oakwood</u>		LOCATION (City, town, or county) (State) <u>Charlottesville Va</u>	
24. REC'D BY REGISTRAR <u>10/14/57</u>		REGISTRAR'S SIGNATURE <u>Julia H. Pary</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Archibald E. Kaplata</u>		ADDRESS <u>La Plata, Md.</u>	

CERTIFICATE OF DEATH

Res. Div. No.

1. USUAL RESIDENCE (HOUSE OR APARTMENT)

MARYLAND

CITY OF BALTIMORE

STREET

APARTMENT

ZIP CODE

DATE OF DEATH

TIME

PLACE

CAUSE

ICD-9 CODE

ICD-10 CODE

ICD-11 CODE

ICD-12 CODE

ICD-13 CODE

ICD-14 CODE

ICD-15 CODE

ICD-16 CODE

ICD-17 CODE

ICD-18 CODE

ICD-19 CODE

ICD-20 CODE

ICD-21 CODE

ICD-22 CODE

ICD-23 CODE

ICD-24 CODE

ICD-25 CODE

ICD-26 CODE

ICD-27 CODE

ICD-28 CODE

ICD-29 CODE

ICD-30 CODE

ICD-31 CODE

ICD-32 CODE

ICD-33 CODE

ICD-34 CODE

ICD-35 CODE

ICD-36 CODE

ICD-37 CODE

ICD-38 CODE

ICD-39 CODE

ICD-40 CODE

ICD-41 CODE

ICD-42 CODE

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ICD-44 CODE

ICD-45 CODE

ICD-46 CODE

ICD-47 CODE

ICD-48 CODE

ICD-49 CODE

ICD-50 CODE

BUREAU V. 1

OCT 16 1957

RECEIVED

SHORT/STENT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be for the files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10573

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10573

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laplata</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Indian Head</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Phy Men's Hospital</u>		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>BERTHA ELIZABETH HARDY</u>		4. DATE OF DEATH <u>10 26 1957</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-27-1978</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wif</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Ch Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William A Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Ann Bailey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>1-27-1978</u>	
17. INFORMANT <u>Ann Alexander Ryan</u>		Address <u>Indian Head Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> DUE TO <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>?</u> DUE TO (c) <u>?</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10-26-57</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Vernon B Dettor</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>VERNON B. DETTOR, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>29 October 1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-29-47</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Southland Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard E Laplata</u>		ADDRESS <u>Indian Head Md</u>	
24a. REC'D BY REGISTRAR <u>Juan H Ryan</u>		24b. REGISTRAR'S SIGNATURE <u>Juan H Ryan</u>	
DATE <u>10/31/57</u>			

MASSACHUSETTS DEPARTMENT OF HEALTH—BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF ATTENDING PHYSICIAN		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF WITNESSES		17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF BURIAL PLACE	
19. SIGNATURE OF CEMETERY		20. SIGNATURE OF INTERVIEWER		21. SIGNATURE OF INTERVIEWEE	
22. SIGNATURE OF INTERVIEWER		23. SIGNATURE OF INTERVIEWEE		24. SIGNATURE OF INTERVIEWER	
25. SIGNATURE OF INTERVIEWEE		26. SIGNATURE OF INTERVIEWER		27. SIGNATURE OF INTERVIEWEE	
28. SIGNATURE OF INTERVIEWER		29. SIGNATURE OF INTERVIEWEE		30. SIGNATURE OF INTERVIEWER	
31. SIGNATURE OF INTERVIEWEE		32. SIGNATURE OF INTERVIEWER		33. SIGNATURE OF INTERVIEWEE	
34. SIGNATURE OF INTERVIEWER		35. SIGNATURE OF INTERVIEWEE		36. SIGNATURE OF INTERVIEWER	
37. SIGNATURE OF INTERVIEWEE		38. SIGNATURE OF INTERVIEWER		39. SIGNATURE OF INTERVIEWEE	
40. SIGNATURE OF INTERVIEWER		41. SIGNATURE OF INTERVIEWEE		42. SIGNATURE OF INTERVIEWER	
43. SIGNATURE OF INTERVIEWEE		44. SIGNATURE OF INTERVIEWER		45. SIGNATURE OF INTERVIEWEE	
46. SIGNATURE OF INTERVIEWER		47. SIGNATURE OF INTERVIEWEE		48. SIGNATURE OF INTERVIEWER	
49. SIGNATURE OF INTERVIEWEE		50. SIGNATURE OF INTERVIEWER		51. SIGNATURE OF INTERVIEWEE	
52. SIGNATURE OF INTERVIEWER		53. SIGNATURE OF INTERVIEWEE		54. SIGNATURE OF INTERVIEWER	
55. SIGNATURE OF INTERVIEWEE		56. SIGNATURE OF INTERVIEWER		57. SIGNATURE OF INTERVIEWEE	
58. SIGNATURE OF INTERVIEWER		59. SIGNATURE OF INTERVIEWEE		60. SIGNATURE OF INTERVIEWER	
61. SIGNATURE OF INTERVIEWEE		62. SIGNATURE OF INTERVIEWER		63. SIGNATURE OF INTERVIEWEE	
64. SIGNATURE OF INTERVIEWER		65. SIGNATURE OF INTERVIEWEE		66. SIGNATURE OF INTERVIEWER	
67. SIGNATURE OF INTERVIEWEE		68. SIGNATURE OF INTERVIEWER		69. SIGNATURE OF INTERVIEWEE	
70. SIGNATURE OF INTERVIEWER		71. SIGNATURE OF INTERVIEWEE		72. SIGNATURE OF INTERVIEWER	
73. SIGNATURE OF INTERVIEWEE		74. SIGNATURE OF INTERVIEWER		75. SIGNATURE OF INTERVIEWEE	
76. SIGNATURE OF INTERVIEWER		77. SIGNATURE OF INTERVIEWEE		78. SIGNATURE OF INTERVIEWER	
79. SIGNATURE OF INTERVIEWEE		80. SIGNATURE OF INTERVIEWER		81. SIGNATURE OF INTERVIEWEE	
82. SIGNATURE OF INTERVIEWER		83. SIGNATURE OF INTERVIEWEE		84. SIGNATURE OF INTERVIEWER	
85. SIGNATURE OF INTERVIEWEE		86. SIGNATURE OF INTERVIEWER		87. SIGNATURE OF INTERVIEWEE	
88. SIGNATURE OF INTERVIEWER		89. SIGNATURE OF INTERVIEWEE		90. SIGNATURE OF INTERVIEWER	
91. SIGNATURE OF INTERVIEWEE		92. SIGNATURE OF INTERVIEWER		93. SIGNATURE OF INTERVIEWEE	
94. SIGNATURE OF INTERVIEWER		95. SIGNATURE OF INTERVIEWEE		96. SIGNATURE OF INTERVIEWER	
97. SIGNATURE OF INTERVIEWEE		98. SIGNATURE OF INTERVIEWER		99. SIGNATURE OF INTERVIEWEE	
100. SIGNATURE OF INTERVIEWER		101. SIGNATURE OF INTERVIEWEE		102. SIGNATURE OF INTERVIEWER	

RECEIVED
NOV 4 1957
BUREAU V. S.

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10574
CERTIFICATE OF DEATH

10574

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Charles</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rison-Rural</u>				c. LENGTH OF STAY IN 1b <u>3-Mths.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>None</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Wanda Lee Hart</u> First Middle Last				4. DATE OF DEATH <u>10-23-57</u> Month Day Year			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Nrgro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-29-57</u>	9. AGE (In years last birthday) <u>3-Mths.</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>24</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William H. Hart</u>				14. MOTHER'S MAIDEN NAME <u>Ella Dalores Riley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>William H. Hart, (Father)</u> Address <u>Rison Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar Pneumonia-Bilateral</u> <u>490x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>24-Hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-18-57</u> , 19 <u>57</u> , to <u>10-23-57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10-23-57</u> , 19 <u>57</u> , and that death occurred at <u>4p</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James E. Andrews</u> M.D.				ADDRESS (Street, city or town, state) <u>Indian Head Md</u>		DATE SIGNED <u>10-23-57</u>	
PHYSICIAN'S NAME (Type) <u>James E. Andrews-17-Potomac Ave Indian Head Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-28-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chapman Church</u>		22d. LOCATION (City, town, or county) (State) <u>Chicamuxer Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm H. Hart</u>				ADDRESS <u>Rison, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>10/25/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary Swethland</u>			

BUREAU V. S.

OCT 29 1957

RECEIVED

10575

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH o. COUNTY <i>Charles</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>md.</i> b. COUNTY <i>Charles</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Phymer Hospital</i>				d. STREET ADDRESS <i>XO Hill Lp. Saplata md.</i>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>CYNTHIA LOUISE HEARD</i>				4. DATE OF DEATH Month Day Year <i>Oct 29 1957</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Feb 24 1934</i>		9. AGE (In years last birthday) yrs. <i>3</i>	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Washington DC</i>		12. CITIZEN OF WHAT COUNTRY? <i>W.D.</i>	
13. FATHER'S NAME <i>Albert Heard</i>				14. MOTHER'S MAIDEN NAME <i>Roseline Heard</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Albert Heard Saplata md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia</i> 517X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>renal failure</i> DUE TO (c) <i>toxic dehydration</i>						INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>3 days</i> <i>9 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>throat infection</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>10-24</i> , 19 <i>57</i> to <i>10-29-57</i> , that I last saw the deceased alive on <i>10-29</i> , 19 <i>57</i> , and that death occurred at <i>2:30</i> P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>[Signature]</i>				ADDRESS (Street, city or town, state) DATE SIGNED <i>Saplata Md 10-29-57</i>			
PHYSICIAN'S NAME (Type) <i>[Signature]</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>10-31-57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Mt Hope</i>		22d. LOCATION (City, town, or county) (State) <i>Fronsdides Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Archart Inc Saplata Md</i>				24a. REC'D BY REGISTRAR DATE <i>10/31/57</i>		24b. REGISTRAR'S SIGNATURE <i>Julia H. [Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
NOV 4 1957
BUREAU V. S.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The burial copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10576

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH COUNTY <u>CHARLES</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Waldorf</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Charles</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Waldorf</u> STREET ADDRESS <u>1</u> (If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>David Oscar</u> (First) <u>HOYLE</u> (Last)		4. DATE OF DEATH (Month) <u>Oct</u> (Day) <u>13</u> (Year) <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Married</u>	8. DATE OF BIRTH <u>May 29, 1878</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sawmill labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sawmill</u>	9. AGE last birthday <u>79</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>13</u> IF UNDER 24 HRS.: Hours <u>19</u> Min. <u>57</u>
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS <u>H. L. Mathew</u> <u>Waldorf</u> <u>MD</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 442X IMMEDIATE CAUSE (A) <u>Respiratory Collapse</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Cardio-vascular-renal disease</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>12 years</u> <u>10 years</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>CVA</u>			<u>9 years</u>
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Aug</u> , 19 <u>50</u> , to <u>13 Oct</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12 Oct</u> , 19 <u>57</u> , and that death occurred at <u>any</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Howard</u> M.D.		ADDRESS (Street, city, town, state) <u>La Plata, Md.</u> DATE SIGNED <u>13 Oct 57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>Oct 15, 1957</u>	NAME OF CEMETERY OR CREMATORY <u>Edenwood Cemetery</u>	LOCATION (City, town, or county) (State) <u>Waldorf, Md.</u>
24. REC'D BY REGISTRAR <u>Julia H. Pacey</u>	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt Hunsford</u>	ADDRESS <u>Waldorf</u>
DATE <u>10/15/57</u>			

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10577

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10577

Reg. Dist. No.

100

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First THOMAS Middle B. Last JEFFERSON		4. DATE OF DEATH Month 10 Day 26 Year 57	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-16-25
9. AGE (in years last birthday) 32 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Lumber	
11. BIRTHPLACE (State or foreign country) Washington, DC		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Thomas Jefferson		14. MOTHER'S MAIDEN NAME Beatrice Butler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unk		16. SOCIAL SECURITY NO. 218 14 3601	
17. INFORMANT Medical Examiner		Address La Plata, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Alcoholism 322.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE William V. Lovitt, Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED	
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> 10/28/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-31-57	
22c. NAME OF CEMETERY OR CREMATORY Mt Zion Meth. Cem.		22d. LOCATION (City, town, or county) (State) Waldorf, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home		ADDRESS Waldorf, Md.	
24a. REC'D BY REGISTRAR DATE 10/30/57		24b. REGISTRAR'S SIGNATURE Julia H. Roney	

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NOV 1 1957

BUREAU V. S.

STATE OF MARYLAND
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10577

NAME: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE: [illegible]
DATE: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10578 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10578

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Md. b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Point, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Physicians Memorial Hospital		d. STREET ADDRESS Charles County	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Jennice Middle Louise Last King		4. DATE OF DEATH Month Oct. 27 Day Year 57	
5. SEX Female	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 2, 1956
9. AGE (In years last birthday) 1 yrs. 3		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Charles Co., Md.		12. CITIZEN OF WHAT COUNTRY? No S.A.	
13. FATHER'S NAME Leroy King		14. MOTHER'S MAIDEN NAME Helen Smothers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dehydration 481X DUE TO Influenza Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH 1 day 3 days			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE J. E. EDELEN		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) J. E. EDELEN		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 10-27-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-30-57	
22c. NAME OF CEMETERY OR CREMATORY Holy Ghost		22d. LOCATION (City, town, or county) (State) Issue, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Richard E. LaPlata		ADDRESS	
24. REC'D BY REGISTRAR DATE 10/31/57		24b. REGISTRAR'S SIGNATURE Julia R. Posen	

UNITED STATES DEPARTMENT OF HEALTH, EDUCATION & WELFARE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]	
3. AGE [Faint text]		4. RACE [Faint text]	
5. DATE OF BIRTH [Faint text]		6. PLACE OF BIRTH [Faint text]	
7. DATE OF DEATH [Faint text]		8. PLACE OF DEATH [Faint text]	
9. TIME OF DEATH [Faint text]		10. CAUSE OF DEATH [Faint text]	
11. MANNER OF DEATH [Faint text]		12. SIGNATURE OF EXAMINER [Faint text]	
13. SIGNATURE OF WITNESS [Faint text]		14. SIGNATURE OF WITNESS [Faint text]	
15. SIGNATURE OF WITNESS [Faint text]		16. SIGNATURE OF WITNESS [Faint text]	
17. SIGNATURE OF WITNESS [Faint text]		18. SIGNATURE OF WITNESS [Faint text]	
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79. SIGNATURE OF WITNESS [Faint text]		80. SIGNATURE OF WITNESS [Faint text]	
81. SIGNATURE OF WITNESS [Faint text]		82. SIGNATURE OF WITNESS [Faint text]	
83. SIGNATURE OF WITNESS [Faint text]		84. SIGNATURE OF WITNESS [Faint text]	
85. SIGNATURE OF WITNESS [Faint text]		86. SIGNATURE OF WITNESS [Faint text]	
87. SIGNATURE OF WITNESS [Faint text]		88. SIGNATURE OF WITNESS [Faint text]	
89. SIGNATURE OF WITNESS [Faint text]		90. SIGNATURE OF WITNESS [Faint text]	
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93. SIGNATURE OF WITNESS [Faint text]		94. SIGNATURE OF WITNESS [Faint text]	
95. SIGNATURE OF WITNESS [Faint text]		96. SIGNATURE OF WITNESS [Faint text]	
97. SIGNATURE OF WITNESS [Faint text]		98. SIGNATURE OF WITNESS [Faint text]	
99. SIGNATURE OF WITNESS [Faint text]		100. SIGNATURE OF WITNESS [Faint text]	

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NOV 4 1957
BUREAU V. A.

BUREAU V. S.

OCT 16 1957

RECEIVED

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The original copy may be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 4, Film G222, 11/1/57 fcy

10580

CERTIFICATE OF DEATH

Reg. Dist. No. 100

10580

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Charles</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Laplace md</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Laplace md</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Phy mem</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print) <u>VERA ALLEN</u> (First) <u>MASON</u> (Middle) <u>MASON</u> (Last)				4. DATE OF DEATH Oct. 18, 1957			
5. SEX <u>female</u>	6. COLOR OR RACE <u>col</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>June 29, 1957</u>	9. AGE last birthday <u>23 months</u>	IF UNDER 1 YEAR Months <u>31</u> Days <u>21</u>		IF UNDER 24 HRS. Hours <u>21</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Charles co</u>		12. CITIZEN OF WHAT COUNTRY? <u>W.I.A</u>
13. FATHER'S NAME <u>Samuel mason</u>				14. MOTHER'S MAIDEN NAME <u>Helen Sawyer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Samuel mason</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
571.0 IMMEDIATE CAUSE (A) <u>MYOCARDITIS</u>				INTERVAL BETWEEN ONSET AND DEATH <u>10-18-57</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>AC INF. DIARRHOE</u>				<u>10-15-57</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 10-25, 1957, to 10-18, 1957, that I last saw the deceased alive on 10-18, 1957, and that death occurred at 4 PM, from the causes and on the date stated above.							
SIGNATURE <u>R. J. Gaden MD.</u>		DATE THEREOF <u>10-19-57</u>		NAME OF CEMETERY OR CREMATORY <u>Sacred Heart</u>		LOCATION (City, town, or county) (State) <u>Laplace md</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. REC'D BY REGISTRAR DATE <u>10/24/57</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Archie Jue Laplace md</u>		ADDRESS <u>10-18-57</u>	

40000182 X 15

[Faint, illegible text from the reverse side of the page, appearing as bleed-through.]

OCT 28 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10581 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10581

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u> c. LENGTH OF STAY IN 1b <u>3 hr 15 min</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Physicians Memorial</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Pomfret</u> b. COUNTY <u>Chas</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XI Rural - Pomfret</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Archibald</u> First <u>Robey</u> Middle Last 4. DATE OF DEATH <u>10</u> Month <u>24</u> Day <u>19</u> Year <u>57</u>				5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>April 17, 1895</u> 9. AGE (In years last birthday) <u>62</u> yrs. IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? _____	
13. FATHER'S NAME <u>Somerset</u>				14. MOTHER'S MAIDEN NAME <u>Georgiana Richards</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) _____ (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT <u>Glady Kline</u> Address <u>2520 17th Ave. N.W. D.C.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> DUE TO (b) <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>331X</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>No injury</u>					
20c. TIME OF INJURY Month, Day, Year <u>1:15 p.m. 24 Oct. 1957</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Pomfret, Charles, Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>V.B. Dettor</u> EXAMINER'S NAME (Type) <u>V.B. DETTOR</u>				DATE SIGNED <u>24 Oct. 1957</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>10-26-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Congressional</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Archibald H. LaPlata</u> ADDRESS _____				24a. REC'D BY REGISTRAR <u>10/24/57</u>		24b. REGISTRAR'S SIGNATURE <u>Julius H. Pomoy</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be for the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the registration prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

OCT 28 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

10583

10582

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <i>Hughesville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hughesville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>CYNTHIA LOUISE SEWELL</i>		4. DATE OF DEATH Month <i>Oct.</i> Day <i>1</i> Year <i>1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 18, 1917</i>
9. AGE (In years last birthday) <i>5 mo</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>JOSEPH FRANCIS SEWELL</i>		14. MOTHER'S MAIDEN NAME <i>THELMA MONROE</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Father - J. F. Sewell - Hughesville</i>		Address <i>—</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Infective Enteritis</i> <i>571.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>—</i> DUE TO (c) <i>—</i>			INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>—</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i>—</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>April 18, 1957</i> , to <i>Oct 1, 1957</i> , that I last saw the deceased alive on <i>Oct 1, 1957</i> , and that death occurred at <i>3:15 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Vahel M. Seron</i> M.D. <i>Aguas, Md</i>		DATE SIGNED <i>10/1/57</i>	
PHYSICIAN'S NAME (Type) <i>VAHEH M. SERON MD</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Oct 2, 1957</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St Marys</i>	22d. LOCATION (City, town, or county) (State) <i>Ryanstown Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Heath Funeral Home</i>		24. REC'D BY REGISTRAR <i>—</i> DATE <i>10/5/57</i>	
ADDRESS <i>—</i>		24b. REGISTRAR'S SIGNATURE <i>Julia H. Pusey</i>	

4000239xv2

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

REV. 10-1-37

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH May 19, 1902	
5. PLACE OF BIRTH Jackson, Mississippi		6. OCCUPATION Minister of the Gospel		7. MARITAL STATUS Single		8. COLOR White	
9. PLACE OF DEATH Baltimore, Maryland		10. DATE OF DEATH April 4, 1968		11. TIME OF DEATH 2:01 PM		12. CAUSE OF DEATH gunshot wound of the back	
13. PLACE OF INTERMENT Greenwood Cemetery		14. DATE OF INTERMENT April 5, 1968		15. TIME OF INTERMENT 10:00 AM		16. NAME OF FUNERAL HOME None	
17. NAME OF PHYSICIAN Dr. J. Morgan Kousser		18. NAME OF SURGEON Dr. J. Morgan Kousser		19. NAME OF PATHOLOGIST Dr. J. Morgan Kousser		20. NAME OF FORENSIC PATHOLOGIST Dr. J. Morgan Kousser	
21. NAME OF CORONER John P. Moore		22. NAME OF JURY None		23. NAME OF JUDGE None		24. NAME OF CLERK None	
25. NAME OF WITNESS None		26. NAME OF WITNESS None		27. NAME OF WITNESS None		28. NAME OF WITNESS None	
29. NAME OF WITNESS None		30. NAME OF WITNESS None		31. NAME OF WITNESS None		32. NAME OF WITNESS None	
33. NAME OF WITNESS None		34. NAME OF WITNESS None		35. NAME OF WITNESS None		36. NAME OF WITNESS None	
37. NAME OF WITNESS None		38. NAME OF WITNESS None		39. NAME OF WITNESS None		40. NAME OF WITNESS None	
41. NAME OF WITNESS None		42. NAME OF WITNESS None		43. NAME OF WITNESS None		44. NAME OF WITNESS None	
45. NAME OF WITNESS None		46. NAME OF WITNESS None		47. NAME OF WITNESS None		48. NAME OF WITNESS None	
49. NAME OF WITNESS None		50. NAME OF WITNESS None		51. NAME OF WITNESS None		52. NAME OF WITNESS None	
53. NAME OF WITNESS None		54. NAME OF WITNESS None		55. NAME OF WITNESS None		56. NAME OF WITNESS None	
57. NAME OF WITNESS None		58. NAME OF WITNESS None		59. NAME OF WITNESS None		60. NAME OF WITNESS None	
61. NAME OF WITNESS None		62. NAME OF WITNESS None		63. NAME OF WITNESS None		64. NAME OF WITNESS None	
65. NAME OF WITNESS None		66. NAME OF WITNESS None		67. NAME OF WITNESS None		68. NAME OF WITNESS None	
69. NAME OF WITNESS None		70. NAME OF WITNESS None		71. NAME OF WITNESS None		72. NAME OF WITNESS None	
73. NAME OF WITNESS None		74. NAME OF WITNESS None		75. NAME OF WITNESS None		76. NAME OF WITNESS None	
77. NAME OF WITNESS None		78. NAME OF WITNESS None		79. NAME OF WITNESS None		80. NAME OF WITNESS None	
81. NAME OF WITNESS None		82. NAME OF WITNESS None		83. NAME OF WITNESS None		84. NAME OF WITNESS None	
85. NAME OF WITNESS None		86. NAME OF WITNESS None		87. NAME OF WITNESS None		88. NAME OF WITNESS None	
89. NAME OF WITNESS None		90. NAME OF WITNESS None		91. NAME OF WITNESS None		92. NAME OF WITNESS None	
93. NAME OF WITNESS None		94. NAME OF WITNESS None		95. NAME OF WITNESS None		96. NAME OF WITNESS None	
97. NAME OF WITNESS None		98. NAME OF WITNESS None		99. NAME OF WITNESS None		100. NAME OF WITNESS None	

BUREAU V. S.

OCT 8 1967

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10583
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 8 Film G222 11-5-57 et
CERTIFICATE OF DEATH

10584

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY Charles MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pisgah				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pisgah			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First William Middle B. Last Simmons				4. DATE OF DEATH Month Oct Day 28 Year 1957			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 26, 1867		9. AGE (In years last birthday) 90 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Florence Simmons		Address Pisgah, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Cardio Renal Disease 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senility DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 7 years 18 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from June , 19 1950 to Oct 28 , 19 57 , that I last saw the deceased alive on Oct 12 , 19 57 , and that death occurred at 7:10 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED James E. Andrews M.D. Indian Shovel Rd 18-30-59							
ACTUAL SIGNATURE JAMES E. ANDREWS M.D.							
PHYSICIAN'S NAME (Type) JAMES E. ANDREWS							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		Nov 4, 1957		St Ignace		Hill Top Md	
23. FUNERAL DIRECTOR'S SIGNATURE Hunt Funeral Home Waldorf, Md				ADDRESS Waldorf, Md		24a. REC'D BY REGISTRAR DATE 10/30/57	
						24b. REGISTRAR'S SIGNATURE Julia H. H. H.	

1. NAME OF DECEASED JAMES M. [illegible]		2. SEX Male		3. AGE [illegible]	
4. OCCUPATION [illegible]		5. MARITAL STATUS [illegible]		6. PLACE OF BIRTH [illegible]	
7. DATE OF DEATH [illegible]		8. TIME OF DEATH [illegible]		9. PLACE OF DEATH [illegible]	
10. CAUSE OF DEATH [illegible]		11. MANNER OF DEATH [illegible]		12. SIGNATURE OF PHYSICIAN [illegible]	
13. SIGNATURE OF REGISTRAR [illegible]		14. SIGNATURE OF WITNESS [illegible]		15. SIGNATURE OF DECEASED [illegible]	
16. SIGNATURE OF DECEASED [illegible]		17. SIGNATURE OF DECEASED [illegible]		18. SIGNATURE OF DECEASED [illegible]	
19. SIGNATURE OF DECEASED [illegible]		20. SIGNATURE OF DECEASED [illegible]		21. SIGNATURE OF DECEASED [illegible]	
22. SIGNATURE OF DECEASED [illegible]		23. SIGNATURE OF DECEASED [illegible]		24. SIGNATURE OF DECEASED [illegible]	
25. SIGNATURE OF DECEASED [illegible]		26. SIGNATURE OF DECEASED [illegible]		27. SIGNATURE OF DECEASED [illegible]	
28. SIGNATURE OF DECEASED [illegible]		29. SIGNATURE OF DECEASED [illegible]		30. SIGNATURE OF DECEASED [illegible]	
31. SIGNATURE OF DECEASED [illegible]		32. SIGNATURE OF DECEASED [illegible]		33. SIGNATURE OF DECEASED [illegible]	
34. SIGNATURE OF DECEASED [illegible]		35. SIGNATURE OF DECEASED [illegible]		36. SIGNATURE OF DECEASED [illegible]	
37. SIGNATURE OF DECEASED [illegible]		38. SIGNATURE OF DECEASED [illegible]		39. SIGNATURE OF DECEASED [illegible]	
40. SIGNATURE OF DECEASED [illegible]		41. SIGNATURE OF DECEASED [illegible]		42. SIGNATURE OF DECEASED [illegible]	
43. SIGNATURE OF DECEASED [illegible]		44. SIGNATURE OF DECEASED [illegible]		45. SIGNATURE OF DECEASED [illegible]	
46. SIGNATURE OF DECEASED [illegible]		47. SIGNATURE OF DECEASED [illegible]		48. SIGNATURE OF DECEASED [illegible]	
49. SIGNATURE OF DECEASED [illegible]		50. SIGNATURE OF DECEASED [illegible]		51. SIGNATURE OF DECEASED [illegible]	
52. SIGNATURE OF DECEASED [illegible]		53. SIGNATURE OF DECEASED [illegible]		54. SIGNATURE OF DECEASED [illegible]	
55. SIGNATURE OF DECEASED [illegible]		56. SIGNATURE OF DECEASED [illegible]		57. SIGNATURE OF DECEASED [illegible]	
58. SIGNATURE OF DECEASED [illegible]		59. SIGNATURE OF DECEASED [illegible]		60. SIGNATURE OF DECEASED [illegible]	
61. SIGNATURE OF DECEASED [illegible]		62. SIGNATURE OF DECEASED [illegible]		63. SIGNATURE OF DECEASED [illegible]	
64. SIGNATURE OF DECEASED [illegible]		65. SIGNATURE OF DECEASED [illegible]		66. SIGNATURE OF DECEASED [illegible]	
67. SIGNATURE OF DECEASED [illegible]		68. SIGNATURE OF DECEASED [illegible]		69. SIGNATURE OF DECEASED [illegible]	
70. SIGNATURE OF DECEASED [illegible]		71. SIGNATURE OF DECEASED [illegible]		72. SIGNATURE OF DECEASED [illegible]	
73. SIGNATURE OF DECEASED [illegible]		74. SIGNATURE OF DECEASED [illegible]		75. SIGNATURE OF DECEASED [illegible]	
76. SIGNATURE OF DECEASED [illegible]		77. SIGNATURE OF DECEASED [illegible]		78. SIGNATURE OF DECEASED [illegible]	
79. SIGNATURE OF DECEASED [illegible]		80. SIGNATURE OF DECEASED [illegible]		81. SIGNATURE OF DECEASED [illegible]	
82. SIGNATURE OF DECEASED [illegible]		83. SIGNATURE OF DECEASED [illegible]		84. SIGNATURE OF DECEASED [illegible]	
85. SIGNATURE OF DECEASED [illegible]		86. SIGNATURE OF DECEASED [illegible]		87. SIGNATURE OF DECEASED [illegible]	
88. SIGNATURE OF DECEASED [illegible]		89. SIGNATURE OF DECEASED [illegible]		90. SIGNATURE OF DECEASED [illegible]	
91. SIGNATURE OF DECEASED [illegible]		92. SIGNATURE OF DECEASED [illegible]		93. SIGNATURE OF DECEASED [illegible]	
94. SIGNATURE OF DECEASED [illegible]		95. SIGNATURE OF DECEASED [illegible]		96. SIGNATURE OF DECEASED [illegible]	
97. SIGNATURE OF DECEASED [illegible]		98. SIGNATURE OF DECEASED [illegible]		99. SIGNATURE OF DECEASED [illegible]	
100. SIGNATURE OF DECEASED [illegible]		101. SIGNATURE OF DECEASED [illegible]		102. SIGNATURE OF DECEASED [illegible]	

RECEIVED
NOV 1 1957
BUREAU V. B.

1. PLACE OF DEATH a. COUNTY <u>Charles Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Hughesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Hughesville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>WILLIAM S. THOMPSON</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>31</u> Year <u>1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>? about 90</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Unknown</u>	
14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>James R. Thompson, Hughesville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocardial Failure</u> 421.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Valvular Heart Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 30</u> , 19 <u>57</u> , to <u>Oct 31</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Oct 30</u> , 19 <u>57</u> , and that death occurred at <u>8:30</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Vahet M. Seron</u> M.D.		ADDRESS (Street, city or town, state) <u>Agassess Md</u> DATE SIGNED <u>Nov 1, 1957</u>	
PHYSICIAN'S NAME (Type) <u>VAHET M. SERON MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/4/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>		22d. LOCATION (City, town, or county) (State) <u>Bryantown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert Funeral Home, Waldorf, Md.</u>		24a. REC'D BY REGISTRAR <u>Julia H. Pasen</u> DATE <u>11/5/57</u>	

VS A15 (4)
15M 9/SS

CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Doe</i>		SEX Male	
AGE 45		DATE OF BIRTH Jan 15 1900	
PLACE OF BIRTH Baltimore, Md.		OCCUPATION Clerk	
MARITAL STATUS Married		DATE OF MARRIAGE Oct 10 1925	
NAME OF WIFE Jane Doe		NAME OF CHILDREN None	
CAUSE OF DEATH Heart Disease		PLACE OF DEATH Home	
DATE OF DEATH Nov 1 1937		TIME OF DEATH 10:30 AM	
SIGNATURE OF PHYSICIAN <i>John Doe</i>		SIGNATURE OF REGISTRAR <i>John Doe</i>	
SIGNATURE OF WITNESS <i>John Doe</i>		SIGNATURE OF WITNESS <i>John Doe</i>	

BUREAU V. S

NOV 2 1937

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10585
CERTIFICATE OF DEATH

10586

Reg. Dist. No. **100**

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CHARLES					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA PLATA			c. LENGTH OF STAY IN 1b 3 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL x1 POPES CREEK			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PHYSICIANS MEMORIAL				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) BRUCE First MATTHEWS Middle WILMER Last				4. DATE OF DEATH Month OCTOBER Day 21 Year 1957					
5. SEX Male		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 27, 1883		9. AGE (In years last birthday) 74 yrs. IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS.: _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer			10b. KIND OF BUSINESS OR INDUSTRY Farming			11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Pere Wilmer				14. MOTHER'S MAIDEN NAME Amelia Matthews					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. IV6		17. INFORMANT Address Mrs. Bruce Wilmer, Popes Creek Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-respiratory failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) hypostatic pneumonia, right chest DUE TO (c) C.U.A								INTERVAL BETWEEN ONSET AND DEATH 3 days 4 days 2 months	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Crown occlusion in 1950.								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from July , 19 48 , to Oct , 19 57 , that I last saw the deceased alive on 21 Oct , 19 57 , and that death occurred at 5:50 P. M, from the causes and on the date stated above.									
ACTUAL SIGNATURE D Wooddy				ADDRESS (Street, city or town, state) La Plata, Maryland DATE SIGNED 22 Oct 57					
PHYSICIAN'S NAME (Type)				M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct 24, 1957		22c. NAME OF CEMETERY OR CREMATORY Mt. Rest		22d. LOCATION (City, town, or county) (State) La Plata, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Hunt & Funeral Home				ADDRESS Waldorf, Md.		24a. REC'D BY REGISTRAR DATE 10/25/57		24b. REGISTRAR'S SIGNATURE Julia H. P...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BULLETIN 18

Reg. No. 1-10

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. AGE [Faint text]		4. DATE OF BIRTH [Faint text]	
5. PLACE OF BIRTH [Faint text]		6. OCCUPATION [Faint text]		7. MARITAL STATUS [Faint text]		8. COLOR [Faint text]	
9. DATE OF DEATH [Faint text]		10. TIME OF DEATH [Faint text]		11. PLACE OF DEATH [Faint text]		12. CAUSE OF DEATH [Faint text]	
13. MEDICAL HISTORY [Faint text]		14. PRESENT ILLNESS [Faint text]		15. TREATMENT [Faint text]		16. POST-MORTEM EXAMINATION [Faint text]	
17. SIGNATURE OF PHYSICIAN [Faint text]		18. SIGNATURE OF REGISTRAR [Faint text]		19. SIGNATURE OF WITNESSES [Faint text]		20. SIGNATURE OF DECEASED [Faint text]	

BUREAU V. S.

OCT 29 1957

RECEIVED

10586

CERTIFICATE OF DEATH

105870

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Charles</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Waldorf</i>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x2 Waldorf</i>			
f. STREET ADDRESS <i>1</i>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Raymond S. Wilson</i> First Middle Last				4. DATE OF DEATH <i>Oct. 27 1957</i> Month Day Year			
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>July 4 1885-72</i> yrs.	
9. AGE (In years last birthday) <i>72</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Govt. worker</i>			
11. BIRTHPLACE (State or foreign country) <i>Wash. D.C.</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Samuel S. Wilson</i>				14. MOTHER'S MAIDEN NAME <i>Katherine Andrews</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>none</i>			
17. INFORMANT <i>R. Edwood Wilson, Waldorf, Md.</i> Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ta. Sequencia</i> 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Dist. S. of Sequencia Cong. Hyena, old Throat TB</i> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Beaten</i> 20c. TIME OF INJURY Month, Day, Year <i>10 - 3 1955</i> Hour o. m. p. m. <i>19</i> 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from <i>10 - 3 1955</i> to <i>Oct 24 1957</i> , that I last saw the deceased alive on <i>Sept 24 1957</i> , and that death occurred at <i>M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>Wm. N. Woodridge</i> M.D. <i>3115 - 4 St N.W.</i> PHYSICIAN'S NAME (Type) <i>Wm. N. Woodridge</i> 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> 22b. DATE THEREOF <i>Oct 29 1957</i> 22c. NAME OF CEMETERY OR CREMATORY <i>Congressional</i> 22d. LOCATION (City, town, or county) (State) <i>Washington, D.C.</i> 23. FUNERAL DIRECTOR'S SIGNATURE <i>Funth Funeral Home, Waldorf, Md.</i> ADDRESS <i>Waldorf, Md.</i> 24a. REC'D BY REGISTRAR DATE <i>10/30/57</i> 24b. REGISTRAR'S SIGNATURE <i>Julia H. Bandy</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10030

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Reg. Dist. 180

PLACE OF DEATH		MARRIAGE	
DATE OF DEATH		DATE OF MARRIAGE	
LOCALITY OF DEATH		LOCALITY OF MARRIAGE	
NAME OF DECEASED		NAME OF SPOUSE	
AGE OF DECEASED		AGE OF SPOUSE	
SEX OF DECEASED		SEX OF SPOUSE	
RACE OF DECEASED		RACE OF SPOUSE	
EDUCATION OF DECEASED		EDUCATION OF SPOUSE	
OCCUPATION OF DECEASED		OCCUPATION OF SPOUSE	
RELIGION OF DECEASED		RELIGION OF SPOUSE	
CAUSE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		MANNER OF DEATH	
SIGNATURE OF DECEASED		SIGNATURE OF SPOUSE	
SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
SIGNATURE OF CLERK		SIGNATURE OF CLERK	

BUREAU V. S.

RECEIVED

THIS CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS NOT TO BE REPRODUCED OR TRANSMITTED IN ANY FORM OR BY ANY MEANS, ELECTRONIC OR MECHANICAL, INCLUDING PHOTOCOPYING, RECORDING, OR BY ANY INFORMATION STORAGE AND RETRIEVAL SYSTEM, WITHOUT PERMISSION IN WRITING FROM THE MARYLAND STATE DEPARTMENT OF HEALTH.